STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005021	A. BUILDING: _____ B. WING _____	C 12/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST ELIZABETH HEALTH - CRAWFORDS	1710 LAFAYETTE RD CRAWFORDSVILLE, IN 47933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This was a State hospital complaint investigation. Complaint: #IN00155242 Unsubstantiated: Lack of sufficient evidence. Facility Number: 005021 Survey Date: 12/15/2014 Surveyors: Saundra Nolfi, RN Public Health Nurse Surveyor Franciscan St. Elizabeth Health Crawfordsville is in compliance with 410 IAC 15-1.5-5, Medical Staff and 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules as related to this complaint. QA Review: JLee 01-16-15	S 000		